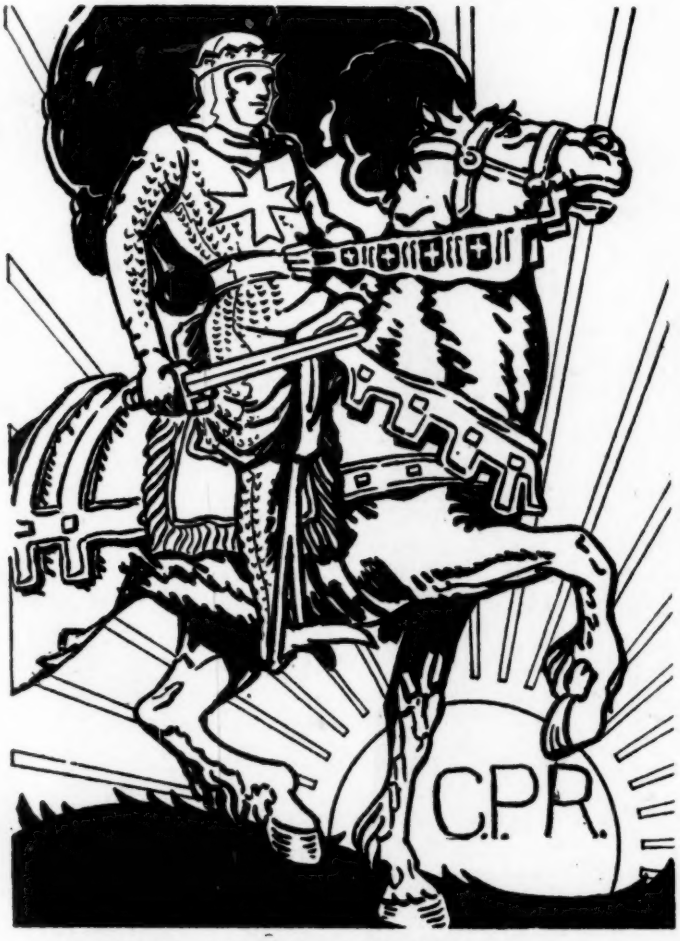
#1

March 1947?

Harlan Wood

ASSOCIATION FOR PHYSICAL and MENTAL REHABILITATION



THE OFFICIAL PUBLICATION OF THE
ASSOCIATION FOR PHYSICAL AND MENTAL REHABILITATION

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GREETINGS AND CONGRATULATIONS

DONALD A. COVALT, M.D.
Assistant Medical Director
Medical Rehabilitation
Washington, D.C.

You in the Corrective Physical Rehabilitation program of the Veterans Administration are engaged in a pioneer field in which we are extending the experiences and valuable lessons of World War II.

In visiting General Medical and Surgical and Neuropsychiatric hospitals all over this country, I have been most highly gratified to note the fine spirit with which you are doing your work and the rapport you have established with the doctor and other hospital workers. I believe this high morale is the result of a psychology of treatment which helps you get close to the patient. The insight you have gained enables you to secure the faith and good will of the patient; he feels that you are working along with him rather than doing something to him. It is my earnest hope that you may continue to seek such friendly contacts in your speciality.

I also want to add my congratulations upon the organization of the Association for Physical and Mental Rehabilitation. Through this unity of effort you will be able to improve your professional understanding of this important field of modern rehabilitation.

* Published with permission of the Chief Medical Director, Department of Medicine and Surgery, Veterans Administration, who assumes no responsibility for the opinions expressed or the conclusions drawn by the author.

TO: Members of The Association for Physical and Mental Rehabilitation

CHAS. R. BROOKE, M.D.
Chief, Physical Medicine
Medical Rehabilitation Service
Washington, D.C.

I take this opportunity to congratulate each and all of the group serving in Corrective Physical Rehabilitation in GM &S and NP Hospitals in the VA. The fine work that you are doing in this specialized program and the spirit of cooperation with other divisions of the Medical Rehabilitation Service is outstanding.

The Corrective Physical Rehabilitation activities play a very necessary and important part in the Physical Medicine program. The mission of the integrated employment of physical therapy, occupational and corrective physical rehabilitation is to carry out scientifically and efficiently the utilization of these therapeutic adjuncts, aimed toward the full medical rehabilitation of the disabled veteran. This method of treatment has achieved its present standing because of the beneficial results now being obtained in the treatment of the mentally and physically handicapped veterans.

TO: Members of The Association for Physical and Mental Rehabilitation

KARL A. MENNINGER, M.D.
Manager, Winter Hospital
Topeka, Kansas
Founder Menninger Foundation

Time was when psychiatry was simply defined as a branch or specialty of medicine. Today we define it rather as a point of view of medicine. According to this point of view the thoughts, the emotions, the behavior of an individual must be considered to be a part of him no less than his flesh and bones and to be capable of pathology for which medical diagnosis and treatment is necessary, available and effective. This point of view, it seems to me, adds a new dignity and a greater importance to the field of technical training in which members of your association are specialized. To lead, to encourage, to direct, to teach a man in a game of handball or a new swimming stroke is a far more significant -- and incidentally a far more difficult -- task than appears to the casual observer. Many a man's recovery from a depression or confusion, capable of life-long crippling, will depend upon the faithful application of the principles of rehabilitation carried out by skillful men possessing full realization of their contribution to a treatment program. Play as you and I envisage it is not a luxury -- it is a necessity, a necessity in every modern hospital.

CORRECTIVE PHYSICAL REHABILITATION IN A NEW WORLD OF MEDICINE

John Eisele Davis, Sc.D., Chief, Corrective Physical Rehabilitation

Dr. Howard Rusk and his coworkers Dr. Donald Covalt and Eugene Taylor, along with many others in the Armed Forces, not only ushered into the arena of medical care, the now accepted third phase of medicine, but they also laid the ground work for new concepts of treatment, producing a profound change in medical practice today.

A leading orthopedist predicted early in World War II, "The last war established orthopedics as a recognized specialty; this war may well do the same for physical medicine." Physical medicine has expanded to include definitive physical therapy, the employment of physical agents for diagnosis, occupational therapy and physical rehabilitation. Along with these components Educational Retraining, Shop Retraining and Corrective Physical Rehabilitation have been added to the therapeutic anamentarium of the Veterans Administration by Dr. Hawley and are being developed to an increasing range of effectiveness under the directorship of Dr. Donald Covalt.

One of the most significant developments through corrective physical rehabilitation is the employment of individualized activity as treatment. This represents a departure from past method of organizing activities for therapeutic purposes, upon an exclusive group basis. The Corrective Physical Rehabilitation personnel are trained to carry out the doctor's prescriptions for individualized activity. The patient is not just another number but is above all an individual with individual needs and potentialities. The Corrective Physical Rehabilitation Chief, as well as the Corrective Physical Rehabilitation Instructor, is a specialist in the application of activity, its modification to the psychological as well as physical need of the patient. For this challenging opportunity he must receive the most thorough, complete and intensive education and experience. He must not only know activities but he must know the patient. He must know the patient not only as a distinctive individual suffering from a distinctive illness, but as a working, feeling organism. He must be able also to give the patient a reason for his activity, to present "a meaning therapy" motivating the sick to utilize all his potentials for getting well, in which the recognition that he is doing it himself and for himself becomes the lure in the motivational process.

Activities are now accorded the dignity of medical adjunctive treatment. No longer can one be typed an impractical idealist who visualizes activities being prescribed for psychological adjustment as one prescribes sodium amytol or sodium pentothal. New techniques in the motor reeducation of the paraplegic patient and others suffering from severe physical disability are being motivated by tying the activities to a job objective. Psychological tests based upon what the psychotic patient actually does in a control situation instead of what he says represent another opportunity for the Corrective Physical Rehabilitation personnel properly trained in psychological as well as physical techniques. This whole area of activities as medical treatment is relatively unexplored and opens vistas of promise for corrective physical personnel. We are appreciative of the significant implications in this situation and want to avail ourselves of a great opportunity to learn.

THE OBJECTIVES
of
CORRECTIVE PHYSICAL REHABILITATION

Louis B. Newman, M. D.
Chief, Medical Rehabilitation Service
Veterans Administration Hospital
Hines, Illinois

Corrective Physical Rehabilitation is the institution of prescribed scientific therapeutic exercises for the disabled; not only for physical improvement but psychological and sociological as well. The Corrective Physical Rehabilitation program, as it functions in the Veterans Administration, is an important activity in the tremendous sphere of endeavoring to restore the handicapped to complete adjustment.

In this age of specialization, one must not forget to treat the entire individual. Disease or injury to any portion of the body affects the entire body and the mind as well. The treatment of the patient's personality must also be included. In the Veterans Administration, the Corrective Physical Rehabilitation program is a section of the Physical Medicine Service, the other sections being Physical Therapy and Occupational Therapy. Corrective Physical Rehabilitation can be successfully applied to almost every type of disability. The program is available for all patients suffering from disease or injury such as cardiac patients; amputees; those with spinal cord injuries; patients with mental disorders; arthritics; those having peripheral vascular disease; brain injuries; etc. This program, being an important phase of rehabilitation, it must be dovetailed into the balance of the program, and, as such, must be under the close supervision and guidance of the patient's doctor. Medical control is essential.

The treatment program must be designed not only to regain the maximum function of the disabled part, but also to regain and maintain the physical fitness of the entire body. Such a program helps to build confidence and courage. It enhances the will to get well.

As soon as the patient's condition warrants, he should receive his corrective Physical Rehabilitation activities off of the ward. A change in surroundings is very stimulating to one's recovery. Much can be done to accomplish this goal while the patient is still confined to bed. It has long been known that the inactivity resulting from being confined to bed soon leads to a marked regression in the general strength and well-being of the patient. It is also well recognized that early ambulation tends to reduce the morbidity rate, lessens complications, decreases the incidence of physical and mental relapses, and hastens recovery. It must be remembered that physical activities for patients differ in many ways from those for normal persons.

After leaving the hospital, this training and instruction can be advantageously used by the patient during his post-hospital convalescence. The activities must be progressive, the

rate of progression depending upon the tolerance of the patient. Therefore, this is an individual problem. It is important not to permit a gap to exist between the hospital and post-hospital regime. Convalescence must be an uninterrupted, progressive, and well-planned program. Make getting well a true incentive to the patient. In order to secure maximum cooperation from the patient in the prescribed activities, the program must be both purposeful and interesting. No fixed results should be established. The activity program must be flexible so as to meet the patient's individual needs. Corrective Physical Rehabilitation must become a part of the patient's program as soon as conditions permit. The personnel on the Corrective Physical Rehabilitation program should regularly furnish the patient's doctor with information relative to the patient's progress. To secure maximum benefits from this exercise program, adequate time must be allotted as part of the patients's daily hospital routine.

While hospitalized, the patient's time must be judiciously used toward restoration to his former capacity. The patient should not be left on his own to find his way back to health. Those in rehabilitation must guide him and lead the way from the bedside until the patient returns to a job. Our work, when properly accomplished, will return the patient to a job in a minimum of time.

SUMMARY

1. Corrective Physical Rehabilitation must be an integral part of the total rehabilitation program.
2. Medical guidance, supervision, and control are essential.
3. A careful evaluation of the patient's condition must be made periodically to determine if satisfactory progress is being made.
4. The activities must be designed around the particular demands of the individual patient. The patient's activity level must be determined. KNOW YOUR PATIENT.
5. Make the program purposeful, interesting, and enjoyable.
6. The benefits of Corrective Physical Rehabilitation to the patient should not only be physical but psychological and sociological as well.
7. Early ambulation should be the goal; movement should be our motto.
8. The success of Corrective Physical Rehabilitation depends upon a full understanding of the patients needs and early patient participation in the program, together with proper, intelligent administration of the activities.

AIDS IN THE ESTABLISHMENT OF THE CORRECTIVE PHYSICAL REHABILITATION PROGRAM

by

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JOHANNES TIMMERMAN
Former Chief, Physical Rehabilitation Officer, 327th Convalescent Center, Chief of Tests and Measurements, 326th Convalescent Center and Instructor, in the R.P.T.I. School, ETO, presently Executive Officer, Medical Rehabilitation Service, VA Hospital, Hines, Illinois

Veterans Administration, Branch Office #7, is honored to have been selected to write a series of articles pertaining to the establishment of a corrective physical rehabilitation program for the first publication of the ASSOCIATION FOR PHYSICAL AND MENTAL REHABILITATION. The material, in the forthcoming articles, is the optimum results of intensified research, conversation, and observation that was instigated in the rehabilitation program as conducted in the European Theatre of Operation, Armed Forces Hospitals in the United States, and the Veterans Administration Hospitals. The outstanding phases of that observed have been compiled and the material will be presented with the idea in mind of assisting the readers in presenting scientific norms, to act as a supplement to their corrective physical rehabilitation program and also in formulating new programs.

Guided by such eminent physicians and surgeons as General Paul E. Hawley, former Chief Surgeon, ETO, and now Chief Medical Director, Veterans Administration, Colonel Rex Diveley, Former Chief Consultant, Medical Rehabilitation Department, ETO, and the former dynamic motivator of the rehabilitation program in the ETO, Colonel Frank Stinchfield. This plus one of the greatest arrays of medical personnel ever assembled, formed the nucleus in the development of medical rehabilitation. Corrective physical rehabilitation was an outgrowth of this development and played an outstanding role in the treatment and return to duty of the battle casualties. Lacking in manufactured remedial equipment, raw material, qualified personnel, and suitable literature, it became necessary to establish a school to qualify personnel in the field of corrective physical rehabilitation. This school was organized at the 307th Station Hospital, Coventry, England, April 15, 1943.

As qualified instructors graduated from the school the personnel problem was alleviated. Through necessity the ingenuity, initiative, "sticktuitiveness", trained ability of these men, the problems of equipment, and program planning, were surmounted. By improvising remedial apparatus, remedial games and their specific usage to fit the therapeutic needs of the patient as prescribed by the physician these deficiencies were remedied. Furthermore, there

was the opportunity of observing the British in the condution of their rehabilitation programs, in which they have had over 100 years of experience. Invaluable material, from these sources, has been acquired, which will be presented in the following issues of this publication.

It will be noted that at the start of the corrective physical rehabilitation program the same problems exist in the Veterans Administration Hospitals which were prevalent in the neophyte state of the ETO rehabilitation program, namely lack of material, equipment, qualified personnel and instructive literature. Because of the experience in overcoming these obstacles in ETO rehabilitation program, the writers are in the position to present to the reader a series of articles, which it is hoped will be benficial in establishing or continuing a successful corrective physical rehabilitation program. Articles on the following subjects which will be submitted for publication in forthcoming issues are: 1. Program Planning; 2. The physical Plant; 3. Improvised and Manufactured Equipment for Hand Clinic, Elbow and Shoulder Clinic, and Psychological Readjustment Clinic. (There will be illustrations of equipment, methods of improvising equipment, and proper usage of same.); 4. Pre-and Post Remedial Tables; 5. Group and Remedial Exercises; 6. Special Remedial Exercises, such as remedial tables for cardiac and rheumatic and specific thoracic remedial breathing exercises; 7. Curriculum for In-Service Training; 8. Physical Fitness Index Tests and Measurements; 9. Individual Psychological Remedial Exercises.

In the presentation of the forthcoming articles, although basically directed to our fellow associates in the Medical Rehabilitation Service, we humbly hope that these articles will be of some benefit to physical education, schools of learning, private hospitals, Armed Forces, private orthopedic clinics, psychiatric clinics and therapists in related fields.

"NOTES OF INTEREST"

The Officers of the organization will meet in the near future to make plans for a National Convention.

Born to Mr. and Mrs Jim Bonner, a girl Elizabeth Clarice--Congratulations.

Congratulations to University of Illinois and Delaware for their Bowl Victories.

Mr. Ed Richardson, Togus Maine will be transferring to Wyoming soon.

Mr. Laurelli, Bedford, Massachusetts has been transferred to Perry Point, Maryland.

Coming Nupitals--Roland Schwartz, Executive Officer, Medical Rehabilitation, Branch Office #7 will marry Miss Hawkins of Springfield, Missouri in the near future. Congratulations.

THE NEED FOR A DEEPER UNDERSTANDING

Dr. George Stafford
Professor Physical Education
University of Illinois

Following all wars except World War II little was done for those whose bodies or minds had been maimed due to the strains of war. It is true that some financial aid was given and institutional care was provided for the casualties who were unable to readjust to post-war conditions, but at best they became the "forgotten men." During and following World War II it was evident that the casualties of this war were to receive a form of consideration quite different from that received by any former group. The casualties of World War II were to be rehabilitated. They were given the best of medical, surgical, psychiatric and physical medicine care while in the hospitals, but, in addition, they were provided with services which aided their return to civilian life with a minimum of impairment due to their wounds or illnesses. Vocational training, counseling and guidance and placement in satisfactory employment was part of their convalescent treatment.

The reconditioning and rehabilitation programs of the armed forces were successful programs. In the main they were accepted as supplementing the traditional forms of therapy. The patients accepted the program, in most imstances, as they accepted other forms of therapy — as a good soldier or sailor accepts an order. During the period of enthusiasm which accompanies actual war many procedures are accepted, which in more tranquil times are scrutinized to the point of doubting. Some of our exercise technicians did not have specific training in corrective or remedial physical education. Their work

had been with vigorous, enthusiastic youths whose chief aim was to make the basketball or football team. Yet they did a splendid job. But now many are questioning their own ability. Many of their patients do not respond to exercise as does the vigorous high school or college athlete. They find themselves at a loss to explain just "why" exercise is so important to the patient whose appetite is good, but who just doesn't have any desire to exercise.

Fortunately the medical profession has seen the value of exercise in the treatment of rheumatic fever, pneumonia, fractures, etc. but what have we done as a profession to add to this knowledge? Have we set up any simple testing devices to show the patient's improvement through exercise in terms of motor fitness improvement, social fitness and emotional stability? Have we learned of the patient's vocational aspirations and set up an exercise program which would strengthen his body parts which must be strong if he is to achieve success in his chosen vocation? Have we gone beyond physical training which deals with training in skills, and begun to do physical education which involves reflective thinking and problem solving?

It has been said so many times that the physical educator has a point of contact with his students which no other teacher has succeeded in obtaining. Do we have that pupil-teacher relationship with our patients? Do they confide in us, seek our advice and council? If not we have missed that important point of contact. This brings up the question of good counselling. Very few physical educators have had sufficient psychology, personality adjustment, personnel and counselling courses which would be of such

help in dealing with hospital patients who need our council and advice. More study is needed along the above lines, more study is needed on the effects of exercise in psychoneurosis, post-operative conditions, fractures, etc. The field is virtually a new field and a deeper understanding of its many ramifications is needed if we are to do a good job, if we are to really give our patients an honest program of rehabilitation.

AFTER TREATMENT OF HEMIPLEGIA

Paul Roland
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Veterans Administration Hospital
Danville, Illinois

1. There are two objects in the after treatment of hemiplegia: (a) to aid the paralyzed muscles in obtaining their lost function; (b) to prevent contractures.
2. Since each case will vary as to the amount of tissue destruction in the brain, the exercise will have to be adjusted accordingly. It is obvious that mush more strenuous exercises can be carried out by a patient who has only a slight weakness in affected muscles than one who has a complete paralysis. Fatigue must be guarded against. Patients must be made to realize that the outcome of the treatment depends on them. Patience, both on the part of the patient and the therapist, together with a persistent encouragement on the part of the latter, are essentials.
3. Exercises should be preceded by baking and massage. Whirlpool bathing, following exercises, will be both pleasant and helpful to the paralyzed extremities.
4. Night splints for both upper and lower extremities to aid in preventing contractures are indicated. These should be started within four days after the cerebral accident.
5. A. Arm: In the beginning, exercises should be carried out in single joints with the other joints uncorrected as follows:
   1. With shoulder in adduction extend and flex the elbow to full range of motion.
   2. With elbow in flexion abduct shoulder first 90 degrees without moving scapula, then so far as possible beyond 90 degrees moving the scapula.
   3. With elbow in flexion, extend and flex wrist to full range of motion. Note: If the normal range of joint motion cannot be obtained by the patient's own efforts alone, he should be assisted by the therapist beyond this maximum angle. Do not force range of motion -- slow gradual relaxation movements.

B. The next step is to carry out the above with the other joints held in a Corrected position as follows:

1. With the shoulder in the normal neutral position extend and flex the elbow to full range of motion.
2. With the elbow in extension abduct the shoulder first to 90 degrees without moving the scapula, then as far as possible beyond 90 degrees moving the scapula.
3. With the elbow in extension and the shoulder in normal neutral position extend and flex the wrist to full range of motion.

Note: The patient can be assisted if he cannot attain full motion.

C. The paralyzed arm may be trained to carry out the exercises with aid from the sound arm as follows: Have the patient grasp a broom handle with both hands close together.

1. Extend and flex elbows.
2. Extend and flex wrists.
3. Raise arms above head with the elbows extended.

D. After the patient has mastered these exercises, he may then carry out the exercises with the weight and pulley apparatus. The weight is used to assist the weak muscles to overcome the spastic ones.

E. Ball exercises will both strengthen the muscles and help to obtain rhythm in motion. Throwing and catching a soft indoor baseball or tennis ball may be carried out. Picking up the ball from the floor and putting it down again is another simple though effective exercise.

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I feel sure this bulletin representing the "Association For Physical and Mental Rehabilitation" will be an aid to your professional advancement. It is hoped the bulletin will aid in professional interchange of ideas and techniques, and the latest findings in research. Contributions will be greatly appreciated by all. May God guide our organization in the promotion of new concepts of medical care that will aid our fellow men in overcoming physical and mental obsticles.

Paul Roland
Director of Publications & Research
Veterans Administration Hospital
Danville, Illinois

Applications for membership should be forwarded to Eli Ellis, Secretary-Treasurer, Veterans Hospital, Canandaigua, New York.